part III: the arkansas HIV/AIDS minority Task Force—2009 Update

In addition to the AMHC FY2009 grants announced in July 2009, in FY2010, AMHC and ADH partnered to release a joint Request for Applications (RFA) for HIV prevention. The RFA represents a unique and novel collaborative effort between ADH and AMHC to foster a statewide coordinated effort to more effectively combat HIV/AIDS in Arkansas. The purpose of this grant is to reduce new HIV infections in Arkansas, and the project will focus on 3 areas:

- HIV testing and counseling
- Prevention for positives
- Prevention based on current modes of transmission

The RFA totaled $600,000 ($350,000 from ADH and $250,000 from AMHC) available for funding for 12-month grants/subgrants. The deadline for submitting applications was October 7, 2009, and the grant recipients were announced early in 2010.[104]

In August 2008, AMHC formed the Arkansas HIV Prevention Coalition, in part to help advance the recommendations of the HIV/AIDS Minority Task Force. With Task Force support, the Coalition has grown to include a number of agencies, including: ADH, UAMS College of Public Health, Jefferson Comprehensive Care System, Inc., the Center for Healing Hearts and Spirits, PARK, a recreational center, St. Mark Baptist Church, STAND News, the Arkansas AIDS Foundation, Jubilee Christian Center, Future Builders, Inc., and the Arkansas Human Development Corporation. The coalition's focus is on high-risk target audiences who are not infected with HIV. These groups include, but are not limited to, African American women, the youth population, and the Hispanic population.[105] In addition, symposia were held at the Arkansas State University in Jonesboro and at the L.V. Floyd Community Outreach Center in Blytheville.

In partnership with ADH, the coalition planned a series of events to commemorate World AIDS Day on December 1, 2009. Designed to increase awareness of and knowledge about HIV, these included a number of community-site testing events, participation by more than 30 churches in 7 counties in "Compassion Sunday" on November 29, a press conference announcing essay and poster contest winners, and a balloon release. Additionally, nationally-known actress and AIDS activist Sheryl Lee Ralph performed her one-woman show entitled *"Sometimes I Cry"— The Lives, Loves, and Losses of Women Infected and Affected by HIV/AIDS,"* and Future Builders, Inc. presented the Fifth Annual Arkansas HIV/AIDS Prevention and Awareness Symposium at Philander Smith College. The symposium's sponsors included the ADH HIV/STD/Hepatitis C Section, AMHC, and the Arkansas HIV Prevention Coalition.

As HIV/AIDS continues to disproportionately affect the minority communities of Arkansas, the Task Force will continue to investigate and propose ways to intervene effectively. To make meaningful progress in the fight against HIV/AIDS, however, will require a greater commitment and investment from the state, as detailed further in the following sections of this report.

part IV: successes, challenges, and opportunities for improving healthcare access

STATE REVENUE AND SPENDING ISSUES

Successes

Fiscal responsibility

Arkansas is a fiscally responsible state and its discipline has served it relatively well in the current economic downturn. The constitution places a general bar against state borrowing and requires that taxes raised from one source be dedicated to a similar purpose. The state's Revenue Stabilization Law has helped the state fulfill its constitutional mandate of a balanced budget by creating a highly structured and regimented budget process. State revenue is distributed into priority-based categories by the legislature. Appropriations flow first to programs in the urgently needed items and finally, if funds remain, the legislature will appropriate monies to items in the "wish-list" category. To comply with these structural requirements, the state legislature passes upwards of 1,300 appropriations bills every year, where many states pass 5 or fewer every year. The state's attention to fiscal detail does not stop at the point of appropriations. After funds are appropriated, the legislature reviews and must give its approval to all contracts worth more than $25,000.[106] These requirements have helped the state to weather the current economic crisis with fewer budget cuts than many states around the nation.

Medicaid Trust Fund

A particularly striking example of Arkansas's fiscal responsibility is the Medicaid Trust Fund. In the early 1990s, Arkansas created a dedicated revenue stream for its Medicaid program. The state has not raided the fund for other purposes, which has allowed it to maintain long-term stability in the state Medicaid program.[107]

Challenges

State budget and revenue

Arkansas is a proudly fiscally responsible state, but its revenue and appropriations policies help make it one of the most inhospitable states in the nation for people living with HIV/AIDS. Arkansas provides zero state funds for HIV/AIDS care. While the state does maintain the HIV/STD/Hepatitis C Section within the Department of Health and has HIV-positive individuals on its Medicaid rolls, no state dollars are dedicated to the AIDS Drug Assistance Program or any other HIV-specific care program. This places Arkansas at the bottom nationally in terms of state contributions to HIV care.[108]

While Arkansas does not provide state funds for HIV/AIDS-specific care and treatment programs, the state has allocated funds for HIV education and awareness. According to Idonia Trotter of the Arkansas Minority Health Commission, (AMHC) Arkansas has contributed approximately $590,000 in FY2009 and FY2010 to HIV/AIDS education and

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awareness in minority communities through the AMHC HIV/AIDS Outreach Initiative Grant Project. In addition, through recent fiscal session supplemental appropriations to the AMHC, Arkansas will contribute another $400,000 during FY2011 to minority communities throughout the state to advance education and awareness campaigns and provide testing in African American, Hispanic, Asian, and American Indian populations. The AMHC's HIV/AIDS Outreach Initiative is administered with tobacco settlement funds through Initiated Act I. The AMHC Board of Commissioners, in early 2008, voted to focus on HIV /AIDS education and awareness in minority communities throughout the state from FY2009-FY2012.

Arkansas tax revenue per capita is near the national average but the burden is significantly focused on low-income communities—the very communities most adversely affected by HIV/AIDS.[109] Arkansas is 1 of only 12 states to levy an income tax on families of 3 who are below the poverty level and 1 of only 16 that levies such a tax on a family of 4. It levies the third highest tax in the nation on a single-parent family of 3 living at the poverty line and the second highest tax in the nation on such families at 125% of poverty.[110]

Every family earning more than $17,716 per year has to pay the tax—one of the lowest incomes to be taxed in the nation. The state has 6 tax brackets from 1% of income up to 7%, with the top bracket at $31,000 and above. Arkansas also raises more than $2B per year in sales taxes while allowing a 30% capital gains tax deduction—policies more immediately helpful to wealthy taxpayers than to low-income workers.

These regressive policies are deeply entrenched. State law requires a three-fourths supermajority for income tax increases while sales taxes require only a majority vote. Additionally, Arkansas's top income tax bracket in 1929 was $25,000, nearly $300,000 in today's dollars, meaning that even as the top bracket has risen to $31,000, Arkansas's income tax has gotten far more regressive in past decades.

Arkansas's relatively regressive income tax is the state's largest source of discretionary revenue. Thirty-two percent ($5.6B) of the state's revenue is classified as general revenue and half of those funds are collected through the personal income tax—approximately $2.7B. The other major driver of general revenue is sales tax, which raises $2.1B per year. Corporate taxes raise only $354M per year and have fallen from 31% of general revenue to 6% in the past 3 decades.

Twenty-three percent of Arkansas's revenue comes from the federal government, 15% is income from state trusts, 9% is special revenue such as license fees, fuel taxes, and other funds mostly earmarked for their collectors. Twenty-one percent of state revenue comes from various cash sources such as interest on state investments, tuition fees, or rent from state property. These funds are typically dedicated for specific agencies and departments, making health spending largely dependent on discretionary state income.[111]

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Within this pool of discretionary revenue, health programs receive $1.04B in general revenue expenditures (24%). While this not insignificant sum ranks behind only K-12 education as a recipient of state funds, the state's regressive revenue generators and the limited pool of discretionary funds apparently leave state officials little flexibility to invest in state HIV programs.

Opportunities

By reorienting some of its taxation priorities or setting a dedicated revenue stream for health programs, Arkansas could significantly improve HIV/AIDS care in the state. The state's Medicaid trust fund, ARKids First, and the state's efforts on prostate cancer screening each demonstrate that a focused state commitment to a public health issue can yield very positive results. To address HIV and other chronic conditions that primarily affect low-income Arkansans, the state must explore ways to raise or reprioritize revenue. Arkansas has significant opportunities to improve conditions for people living with HIV/AIDS in the state if they reverse the rapid decline in corporate taxation, shift the tax code away from a heavy reliance on low net worth individuals, or loosen the rigid allocation of state trust and cash income.

MEDICAID IN ARKANSAS

Successes

ARKids First

Arkansas's Medicaid program is one of the most generous in the nation in terms of covering children. ARKids First A and B have been extremely successful in expanding children's access to health insurance. Together, the programs have helped Arkansas cut the rate of uninsured children from 21% in 1997 to 9% in 2009.[112] The programs cover more than 343,000 children, 70,000 of whom would otherwise have gone without health insurance.[113]

The programs' success is due to expanded eligibility criteria for children and a generous federal match rate. While Arkansas's Medicaid program has strict income and asset levels for adults, there is no asset test for children, and ARKids First opens up coverage to kids with family incomes up to 200% FPL. The federal match rate for regular Medicaid is 73%, still high by national standards, but it is 82% for ARKids First.[114]

As a result of these programs, 78% of poor children receive Medicaid in Arkansas, compared with 64% nationally, and 92% of Arkansas's children are insured, compared with 89% nationwide.[115]

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Challenges

As currently designed, Arkansas's Medicaid program presents significant challenges to low-income individuals' access to healthcare. The challenges are particularly acute for individuals living with HIV/AIDS. Arkansas is one of the poorest states in the nation with the third lowest median income, ranking above only Louisiana and Mississippi.[116] Given that average health premiums have risen 5 times faster than wages in recent years, that Arkansans pay the second highest premium share of any state in the country, and that Arkansas employers insure a lower percentage of workers than in most states around the country, a substantial percentage of the state's citizens either are not provided or cannot afford insurance through the private or employer marketplace.[117] These factors combine to create a significant demand for health insurance through public programs like Medicaid.

Despite, or perhaps because of, this tremendous demand for services, Arkansas has some of the most rigorous eligibility standards and one of the least generous benefits packages of any Medicaid program in the nation.

Working parents and nondisabled individuals are not eligible for Medicaid unless they earn less than $255 per month—$3,060 in a year. This represents just 17% of the FPL. The average national income eligibility level is $11,928, or 68% of the FPL.[118] In addition to these strict income limits, a nondisabled family of 3 is only eligible if they have less than $1,000 in assets.[119]

Arkansas has a medically needy category called "Medicaid spend-down." The program limits eligible individuals' income to $108 per month (15% of the FPL) and $2,000 in assets after they "spend down" the rest of their funds on medical care. For couples the income level is $217 per month (22% of the FPL) and the asset limit is $3,000.

Once enrolled in Medicaid, Arkansans are offered an extremely limited benefits package. Medicaid covers a maximum of 12 hospital outpatient visits, 12 office visits, 1 basic family planning visit, and 3 periodic family planning visits. For most adult beneficiaries there is a maximum of $500 in laboratory and x-ray services and a maximum of 24 inpatient hospital days per year.[120] Adult beneficiaries outside of nursing homes are limited to 3 pharmaceutical prescriptions, including refills, per month. Extensions may be granted for a maximum of 6 prescriptions per month for beneficiaries at risk of institutionalization.

These prescription limits are particularly challenging for people living with HIV/AIDS because of their significant medication requirements and the major contraction in the state's AIDS Drug Assistance Program (ADAP). AIDS Drug Assistance Program eligibility has dropped from 500% FPL to 200% FPL. Additionally, the new eligibility requirements specifically bar any individual on Medicaid from participating in ADAP.[121]

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Arkansas also requires cost sharing by beneficiaries. Some beneficiaries pay the first 10% of the first day of hospital stays, and some must pay 50 cents to $3 of each prescription. Beneficiaries in the working disabled aid category are required to pay 25% of the charges for the first day of inpatient hospital service, and have a higher copayment on some additional services.[122]

While Arkansas Medicaid does offer home- and community-based services through a waiver program, there is a significant waitlist for the services and the program does not have a category for those living with HIV/AIDS.[123]

The end result of these restrictions is that people living with HIV/AIDS must be either extremely poor or significantly disabled by their disease to qualify for Medicaid coverage. The narrow eligibility and the limited benefits if individuals do qualify drive a significant number of uninsured or underinsured individuals to the emergency room for care. This care is often significantly more expensive for individuals, the state, and, ultimately, consumers of healthcare that have insurance. Uncompensated care for the uninsured represents a multibillion-dollar "hidden health tax" of $1,500 per year on every Arkansan with health insurance.[124] The lack of coverage and benefits also likely contributes to Arkansas's startlingly high percentage of unmet need for those living with HIV, its high and rapid rates of AIDS diagnosis for newly-diagnosed HIV-positive individuals, and its high and rapid death rate for newly-diagnosed individuals.

Opportunities

With such high system-wide costs arising (in part) from the restrictions in the state's Medicaid program, the most obvious opportunities are to expand eligibility and benefits. The high up-front cost of such an action could make it difficult, but such an expansion could drastically improve hundreds of thousands of lives and save Arkansans billions per year in uncompensated care costs, premiums, and tax revenue.

Early Treatment for HIV Act

Other states have increased Medicaid access for people with HIV/AIDS by creating a presumptive eligibility category and by using waivers to cover predisabled HIV-positive individuals. Both Massachusetts and Maine have waivers allowing HIV-positive low-income people to qualify for Medicaid. Earlier access to Medicaid can actually reduce costs, as people with earlier access to care stay healthier longer, and can avoid more expensive medical interventions.

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The federal Early Treatment for HIV Act (ETHA), which is modeled on the Breast and Cervical Cancer Prevention and Treatment Act of 2000, would expand on the Maine and Massachusetts examples. ETHA would give all states the option of providing Medicaid coverage to low-income, predisabled people living with HIV, and would provide states with enhanced FMAPs for the program. Advocates should ask Arkansas's members of Congress to cosponsor and actively support passage of ETHA.

Home- and community-based services for HIV

Given the debilitating effects of HIV/AIDS and the medical treatments used to combat it, home- and community-based services (HCBS) can be critical for many consumers of care. Arkansas has a waiver to provide HCBS under Medicaid, but does not list HIV-positive individuals as an eligible category. Expanding eligibility to people living with HIV/AIDS could significantly improve access to Medicaid and health outcomes.

Roll back new AIDS Drug Assistance Program limits

Arkansas's new restrictions on its AIDS Drug Assistance Program (ADAP) pose a real threat to the health of individuals living with HIV/AIDS. By barring Medicaid beneficiaries, the new ADAP limits will force many low-income Arkansans to rely on the limited pharmaceutical benefits offered under Medicaid or the charity of pharmacy assistance programs. The state should roll back the ADAP cuts by requesting federal ADAP supplemental funding and/or committing some state resources to cover the added cost.

Reimbursement rates

Low Medicaid reimbursement rates are a critical barrier to individuals seeking care. An increasing number of medical providers find that they cannot afford to provide care at the Medicaid-reimbursed rate, and consequently do not accept Medicaid patients in their practices.

Targeted case management for people living with HIV and AIDS

Arkansas should ask for a waiver to cover targeted case management for people living with HIV/AIDS. The state offers targeted case management for youth, children, the elderly, pregnant women, and individuals with disabilities. HIV is a severely debilitating disease that requires significant regular care and treatment management. Arkansas should follow Alabama's lead to cover case management for HIV-positive individuals through Medicaid.

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Expand ARHealthNetworks

ARHealthNetworks is an innovative state effort to expand coverage to previously uninsured individuals that could be expanded to make up for deficiencies in the core Medicaid program. The program was designed to allow employers who had not previously provided health insurance to their employees to provide a "safety net" benefit package through a public-private partnership. The program covers workers at or below 200% FPL at businesses with fewer than 500 employees that have not had a health plan for more than 1 year—a significantly more expansive eligibility criteria than traditional Medicaid (17% FPL).

The plan's benefits are not more generous than the core Medicaid package, but it does prohibit denial of coverage for preexisting conditions and helps subsidize premiums.[125] Despite its deficiencies and narrow enrollment, ARHealthNetworks demonstrates a meaningful effort to expand coverage to low-income and difficult-to-insure Arkansans. Expanding the program to more employers or part-time workers or improving the benefit package could significantly improve coverage and public health in Arkansas.

ISSUES RELATED TO THE ARKANSAS DEPARTMENT OF HEALTH HIV/STD/HEPATITIS C SECTION

Successes

After a troubled recent past characterized by fiscal mismanagement, staff turnover, and a lack of oversight, the HIV/STD/Hepatitis C section of the Infectious Disease Branch within the Arkansas Department of Health's (ADH) Center for Health Protection has taken significant steps to improve quality, performance, and accountability. Over the past year and a half, the new management team has demonstrated a willingness to critically examine its programs and assess what is not working. The staff have undertaken a number of initiatives to enable the section to better fulfill its mission of preventing new HIV infections and maximizing access to care and services for Arkansans living with HIV/AIDS.

The section's HIV Services Program (HSP), which is responsible for administration and oversight of Ryan White Part B-funded care and services, developed a Quality Improvement (QI) Plan to improve the quality and effectiveness of the HIV service delivery system in Arkansas. As part of the process of creating the QI Plan, HSP convened a Transition Advisory Group, including community-based providers and

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people living with HIV/AIDS, to provide input and recommendations on transitioning Arkansas's existing HIV continuum of care to a model that meets the current requirements of the Ryan White HIV/AIDS Treatment Modernization Act. With technical assistance from the Health Resources Services Administration (HRSA), the QI Plan was published in May 2008.[126]

Following the QI Plan, ADH launched the Service Access Improvement Initiative, a pilot project undertaken in eastern Arkansas to test a new model of providing core medical and support services.[127] The success of the pilot project led to ADH issuing a Request for Applications in October 2009 to seek applicants to provide HIV Service Access Centers as part of the state's Ryan White Part B program. The Arkansas Department of Health plans to fund 15 service access centers across the state, with funding anticipated to begin April 1, 2010.[128] These centers will replace the ConsortiaCARE system.

Along with revamping the HIV service delivery model, and adopting a quality management program, ADH has also made more of an effort to involve consumers (people living with HIV/AIDS) in its planning and decision making. The Arkansas Department of Health has convened a Consumer Advisory Board (CAB), which will have representation from consumers in all regions of the state. The CAB meets monthly and provides recommendations to ADH on ways to better address consumers' needs.

On the prevention side, ADH staff members have met with high-ranking staff from the Centers for Disease Control and Prevention[129] (CDC) to explore ways to better reach higher-risk populations with education, testing, and prevention messages. As a result of these meetings, the HIV Prevention staff will be revising the composition and scope of the Arkansas Community Planning Group and creating a comprehensive prevention plan for the state. The Arkansas Department of Health has also created a new prevention-focused partnership with the Arkansas Minority Health Commission that aims to eliminate health disparities in HIV/AIDS by increasing awareness and testing to ultimately improve the health of all Arkansans.

Challenges

This remains a time of significant transition for the HIV/STD/Hepatitis C section, and like all times of transition, has generated some anxiety, uncertainty, and resistance to proposed changes. There are also certain structural issues within ADH and state government that compromise the section's ability to do its job in the most efficient and effective way possible.

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Communication and collaboration with the community

While there is widespread agreement that communication among the Arkansas Department of Health (ADH) and community-based providers and consumers is much better than it used to be, there remains room for improvement. Particularly at times of serious changes to service eligibility (such as the recent cut in financial eligibility levels for Ryan White services and the AIDS Drug Assistance Program [ADAP]), ADH needs to ensure that information is communicated in a timely, clear, consistent, and thorough way. Consumers expressed the desire for one "point person" within ADH to be the contact for getting important messages about services out to consumers. The new Consumer Advisory Board should also be able to help with conveying information.

Some community-based providers and consumers expressed frustration at a perceived "top-down" approach by ADH—the sense that big decisions were made without adequate consultation of the people who would be most affected or of providers with significant experience in direct service provision. Some cited a lack of "on the ground" field experience on the part of ADH Central staff and an unwillingness to hear the perspectives of those working directly with clients.

The Arkansas Department of Health has endeavored to include providers and consumers in its assessment and planning processes. Part of the problem may lie in the fact that ADH has abrogated some of its responsibilities in the past, such as administration of ADAP, delegating responsibilities to community-based providers. A reassertion of central authority over some functions may cause community-based providers to feel that their contributions over the years are not being adequately respected or valued.

One other challenge voiced by community-based providers is the amount of documentation and paperwork now required by ADH. While there is an understanding of the need for evaluation and quality monitoring, some providers feel that they are confronted with a choice of helping clients or doing the paperwork required to receive the funding they need in order to help clients. Case managers often feel that there are so many demands on their time that they can only "put out fires" for clients, rather than perform proactive case management.

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Surveillance

In the Arkansas Department of Health (ADH), all registries (surveillance) are grouped under the Health Statistics Branch, and all epidemiologists under the Epidemiology Branch. This arrangement is designed to ensure technical competence in a relatively small health department, but also means that HIV/AIDS/STD surveillance is not under the direct jurisdiction of the HIV/STD/Hepatitis C section chief. The state AIDS director therefore does not have control over the day-to-day collection, monitoring, and movement of key data. Surveillance staff are supposed to provide a weekly report of the number of new HIV and STD cases to the HIV/STD program epidemiologist, so that the epidemiologist can monitor for spikes and outbreaks of disease. However, the section chief of the HIV/STD/Hepatitis C section reports never having seen one of these weekly reports. This situation has been further complicated by the fact that the HIV/STD program epidemiologist position was vacant for an extended period in 2009 (although due to be filled in mid-December 2009). In the past, a consultant working with the HIV Services Program also reported difficulty obtaining timely and accurate surveillance data.

Accurate, timely data are essential to responding quickly to disease spikes and outbreaks, targeting interventions effectively, monitoring quality, and making the most efficient and effective use of limited resources. Reliable data also form the core of ADH's ability to successfully compete for grant funding and to comply with federal reporting requirements. A data summary done in 2008 by the ADH Region VI data coordinator found data completion rates of 99-100%, exceeding benchmarks. Arkansas Department of Health surveillance staff report that upon notification by a laboratory of a positive HIV or STD test, information is entered into the system and sent to disease intervention specialists within 24-48 hours. Arkansas Department of Health surveillance staff members also report that they do both "active" and "passive" surveillance by conducting medical record reviews, making site visits, and following up on incomplete laboratory reports, as well as waiting for reports to come in from providers, including case managers.

A significant problem up to this point has been inadequate communication between surveillance and the HIV/STD/Hepatitis C section, exacerbated by key personnel vacancies. It is telling that the HIV/STD/Hepatitis C section chief has not seen either the weekly surveillance reports or the 2008 data summary. Conducting accurate and timely surveillance is critical, but is just one part of the job. The data collected must also be effectively shared with the section tasked with designing programs, controlling disease, and applying for federal funding. Across the country, 77% of states address this issue by siting their surveillance programs under the jurisdiction of the state AIDS director.[120]

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Bureaucratic state contract rules

While Arkansas is known for its fiscal restraint, the complex system of state contracts and the different sets of rules involved can create a cumbersome situation that hinders changes that could make programs more efficient and effective. One example of this is the AIDS Drug Assistance Program (ADAP); ADAP had been set up to require clients to go through their case managers to obtain refills of prescription medications, rather than being able to call the pharmacy directly to request refills. This added an extra layer of administration and expense to the ADAP process. Because of the nature of the contract with the pharmacy, however, ADH was unable to modify the contract to allow clients to directly obtain their medications.

Opportunities

Consider creating a Consumer Office within Arkansas Department of Health

With the creation of the Consumer Advisory Board, the Arkansas Department of Health (ADH) is doing better at seeking input from consumers and involving them in decisions about the systems of care that directly affect them. ADH could also explore the possibility of creating a Consumer Office, staffed by a person living with HIV/AIDS, within the HIV/STD/Hepatitis C section, as some other states have done. The primary advantage of an internal Consumer Office is that the perspective and experience of a person living with HIV/AIDS and representing consumers would be incorporated into the day-to-day operations and decisions of the section. The Consumer Office manager could be the liaison between the section and Arkansas consumers, helping to achieve better communication and greater transparency, and to promote better understanding of ADH policy and program decisions among consumers. Having a consumer as part of ADH staff could also engender more trust and support of the Health Department on the part of consumers.

Continue to seek input from the field—and go there

While significant changes may be necessary to implement a service delivery model that better serves Arkansans living with HIV/AIDS (especially in economically challenging times), the Arkansas Department of Health (ADH) should be careful not to go too far. Longtime community-based providers may be resistant to change and have entrenched ways of doing things, but may also possess valuable knowledge of the particular needs and characteristics of the communities they serve. This knowledge should be respected and sought out by ADH as programs are developed, and providers should be given meaningful ways to provide input and feedback. ADH staff should also consider longer site visits to programs outside the Little Rock area to develop a more in-depth understanding of the unique needs in different regions of the state.

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Improve communication and consider moving some surveillance functions under the jurisdiction of the HIV/STD/Hepatitis C section chief

The Arkansas Department of Health needs to create a mechanism for better communication and coordination among surveillance, epidemiology, and client services program staff, as well as better sharing of data. Simply put, there must be better teamwork within ADH. Seventy-seven percent of states give their AIDS directors jurisdiction over surveillance. The Arkansas Department of Health (ADH) should seriously consider siting the day-to-day collection, monitoring, and movement of data under the HIV/STD/Hepatitis C section, while keeping the more in-depth analysis of data with the technical experts in the surveillance and epidemiology programs. This would help ensure that the HIV/STD/Hepatitis C section has timely access to the data it needs to design programs, evaluate quality, and meet grant requirements, helping to fulfill its mission more efficiently and effectively.

Examine state public health structure and funding allocation

The new leadership of the HIV/STD/Hepatitis C section has reached out to collaborate with other health-oriented state agencies, such as forming a prevention-focused partnership with the Arkansas Minority Health Commission to encourage HIV awareness and testing among Arkansas's minority communities. This is a good start to promote greater coordination of health efforts. The state should also look at ways of structuring its health-related efforts to improve effectiveness, coordination, and accountability, and to maximize the use of limited resources.

Centralize functions and streamline paperwork

Where it makes programmatic and economic sense to do so, Arkansas Department of Health should centralize some functions that have in the past been delegated to the community provider level. The AIDS Drug Assistance Program is one example of this. This will help give case managers in the field more time to work with clients. Paperwork and reporting requirements should be streamlined to the extent possible, while still maintaining compliance with federal requirements and acquiring sufficient information to monitor service quality.

Revise cumbersome state contracting rules

Arkansas should explore changing policies and regulations, particularly concerning contracts, that obstruct state agencies' ability to be agile and responsive to problems.

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HIV-RELATED STIGMA

Successes

Some progress has been made in Arkansas in increasing awareness and decreasing HIV-related stigma over the more than quarter-century of the US AIDS epidemic. From December 2007 to February 2008, the Arkansas Minority Health Commission (AMHC) and Jefferson Comprehensive Care System, Inc. cosponsored an HIV prevention billboard campaign titled "HIV/AIDS Affects Us All: It's Time to Talk." The campaign featured prominent community leaders, including several leaders from faith communities.[131] Jefferson Comprehensive Care System, Inc. has also produced video public service announcements targeted at youth HIV prevention, with the support of the Cable Positive Foundation.

In 2009, more than 30 churches in 7 counties (Crittenden, Jefferson, Mississippi, Phillips, Pulaski, Union, and Washington) participated in "Compassion Sunday" (the Sunday following Thanksgiving), educating congregants about HIV/AIDS. The 7 counties featured have some of the highest incidences of HIV in the state.[132] Many historically black colleges and universities have participated in HIV testing events, often with long lines of students waiting to be tested. There are some highly respected church leaders who incorporate HIV/AIDS work into their ministries, including Bishop Steven M. Arnold of St. Mark Baptist Church and Reverend William Robinson of Theressa Hoover United Methodist Church, both in Little Rock. Some providers in larger population centers or more affluent areas of Arkansas perceive that HIV-related stigma is much less of a problem than in the past, although there is not unanimous agreement on this.

Challenges

Despite some progress, stigma, discrimination, fear, and ignorance about HIV remain widespread in Arkansas. HIV/AIDS stigma is a multifaceted and nuanced phenomenon that can manifest in many different ways and is inextricably intertwined with other forms of discrimination, including racism and homophobia. HIV-related stigma in Arkansas is partly due to the association of HIV with behaviors often considered shameful, such as injection drug use, promiscuity, and male-to-male sex. Stigma occurs in all settings, including healthcare facilities. In February 2009, a 75-year-old retired professor was allegedly evicted from a North Little Rock assisted-living facility one day after moving in because of his HIV-positive status, which he had disclosed on his application.[133]

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Arkansans living with HIV/AIDS and their service providers report high levels of fear and ignorance about HIV among the general public, particularly within socioeconomically and educationally disadvantaged communities. This includes a lack of knowledge of even the basic facts about how HIV is and is not transmitted (eg, that HIV cannot be transmitted by sharing a drinking glass). Consumers also report poor treatment in a variety of healthcare settings, including emergency rooms, dental offices, and pharmacies.

HIV/AIDS stigma has profoundly negative implications for both prevention and access to care. It affects people's health-related decisions, including delaying HIV testing, putting off needed care, and not disclosing HIV status to sexual or drug-using partners or medical providers. Stigma affects both individual and public health. People who are unaware of their HIV status are more likely to transmit the virus, and people who are late to enter care are often more ill. This can also lead to economic consequences, in the form of lost productivity and the need for higher-cost medical interventions.

Stigma experienced in family and social settings, as well as the perception that the public harbors widespread fear and negativity toward people living with HIV/AIDS, may lead to greater secrecy and isolation on the part of those living with the virus. This can hinder prevention and education campaigns and efforts to link people living with HIV/AIDS with healthcare and services. Stigma also undermines public education about HIV by discouraging people living with the virus from disclosing their status and participating in education efforts.

Stigma in rural Arkansas

One provider of HIV care and services in rural Arkansas noted that "we're where the rest of the country was in the late 1980s." Another who provides HIV testing mentioned that people would often park around the corner and take care not to be seen walking into the office. Many rural providers agree that people living with HIV/AIDS are hesitant to seek care within their own communities because of the "smallness" of rural towns, and the fear of others "knowing their business." Stories abound of people's HIV status being disclosed to others—often by staff of health clinics, who should be the front lines of preserving confidentiality. There are often no remedies for people who have had their confidentiality violated, as the same stigma and fear keeps them from filing complaints under the Health Insurance Portability and Accountability Act (HIPAA), the federal law protecting medical information privacy. Providers report that African American clients are often unwilling to visit county health units, a reluctance understandable in the long shadow of Tuskegee.

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Stigma among faith communities

Arkansas is a largely socially conservative state where many people hold strong, traditional religious beliefs. While some churches have demonstrated leadership on HIV/AIDS issues, others have either remained silent about HIV or have contributed to HIV-related stigma by preaching that AIDS is a curse from God for sinful ways. Some African American Arkansans living with HIV/AIDS have commented that their churches are the "biggest obstacles" to acceptance and compassion for people living with the virus.

Opportunities

Education for the public and healthcare providers

With a lack of knowledge of even the most basic facts about HIV, more public education is clearly indicated. While there is some skepticism among consumers that the people most in need of education are the ones least willing to listen to messages about HIV/AIDS, there should be ways to make "HIV 101" information accessible to everyone. The Department of Health (particularly the Consumer Advisory Board (CAB) and the Arkansas Minority Health Commission (AMHC) should be the lead government agencies in educational initiatives. The HIV/AIDS Minority Task Force has proposed involving local community leaders in designing education programs about HIV. This approach makes sense, as it is likely to develop educational messages that respect community mores while communicating factually accurate information about HIV/AIDS. In addition to education for the general public, more specialized education for healthcare providers and people working in healthcare facilities seems warranted. This could include information reviewing universal precautions and discussing the damaging effects of stigma. Wherever possible, people living with HIV/AIDS should be part of educational efforts. This can help personalize the issue, break down fear and prejudice, and overcome the mentality of "only ***those*** people get AIDS."

Create an antistigma campaign using social media

In 2009, the Western North Carolina AIDS Project (WNCAP) launched a media campaign to combat stigma in largely rural western North Carolina.[134] Entitled "i need u2 know," the campaign is designed to raise awareness about how HIV/AIDS affects everyone in the community, not just people living with the illness, and to show support for people living with HIV/AIDS. The campaign features television public service announcements, as well as an online petition with a goal of collecting 5,000 signatures, and makes use of social media sites as well as more traditional media like posters, bumper stickers, and billboards. The campaign is privately supported by the Cable Positive Foundation, with a local production company and cable channels also donating time and talent. WNCAP's campaign could be

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a model for a similar campaign in Arkansas, and antistigma efforts in other southern states can also be explored. Incorporating social media such as Twitter, Facebook, and MySpace into an antistigma campaign may also be an effective way to reach younger audiences.

Seek help from supportive clergy and tailor messages

While many churches remain silent or are actively stigmatizing about HIV/AIDS, there are some notable prominent community faith leaders who have been supportive of people living with HIV/AIDS and who have shown a willingness to include HIV prevention and services into their ministries. Guidance should be sought from these leaders about the most effective ways to reach out to other clergy and the messages that might resonate with them about the need for both HIV prevention education and compassion for people living with HIV/AIDS. As with any culturally competent efforts, initiatives with faith communities (both clergy and congregants) need to both understand where people are coming from and meet them where they are. There are materials available that deliver faith-based, factually accurate messages about HIV/AIDS that could be incorporated into efforts in faith communities.[135]

Routinize voluntary HIV screening and require insurance coverage

In 2006, the Centers for Disease Control and Prevention (CDC) announced new recommendations for HIV testing, recommending that voluntary, opt-out HIV screening be part of routine medical care for everyone ages 13 to 64.[136] The recommendations were designed to increase early HIV diagnosis among the estimated 250,000 Americans who do not know that they are HIV-positive, and to bring people into care earlier, when they can best benefit from new treatments. Increasing the number of people aware of their HIV status is a key element in prevention and care efforts. Earlier knowledge of HIV status benefits both individual and public health, and also has economic benefits in the form of lower-cost medical interventions and prolonged productivity.

Routine, voluntary, opt-out (ie, giving people the right to decline to be tested) screening can also be a way to destigmatize HIV. Making HIV screening a regular part of medical care, like cholesterol tests or blood pressure screening, can help "normalize" HIV and make it less intimidating. If everyone were tested for HIV, the stigma, blame, and shame currently often associated with HIV testing could be markedly reduced. Arkansas should consider requiring health benefit plans to cover 1 annual HIV test for people ages 13 to 64, in line with the CDC recommendations. There are similar insurance mandates for certain other diseases, such as prostate cancer.[137] (This recommendation of course raises the question of how to provide routine screening to the many Arkansans without health insurance, but is at least a starting point toward increasing knowledge of HIV status and reducing stigma.)

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PROVIDER SHORTAGES AND CAPACITY

Successes

According to a 2007 report from the National Association of Health Centers and the Robert Graham Center, Arkansas does slightly better than the national average in terms of the percentage of its residents who are "medically disenfranchised" (defined as lacking adequate access to a primary care physician due to a local shortage of physicians). In 2005, about 19% of people nationally were medically disenfranchised, compared to 18.5% in Arkansas.[138] Arkansas has a strong network of community health centers/federally qualified health centers, and the Arkansas Department of Health (ADH) operates 94 local health units in all 75 Arkansas counties.[139] The Hometown Health Improvement (HHI) initiative encourages local communities to take collaborative action to improve health, with support from ADH. According to the ADH Web site, 73 HHI initiatives currently exist around the state.[140]

State law and policy makers have recognized the need for more medical providers, especially in rural areas. Arkansas has a rural medical practice student loan and scholarship program to provide assistance to physicians who choose to enter rural practice.[141] The University of Arkansas for Medical Sciences (UAMS), the state medical school, is currently expanding its capacity with a satellite campus in northwest Arkansas (Fayetteville), which is expected to eventually accommodate 250-300 students.[142] In the 2009 legislative session, lawmakers approved an increase in the tobacco tax,[143] with the proceeds intended to go to health-related initiatives, including a $1M allocation divided among charitable clinics around the state. Arkansas also has a statewide network of area health education centers (AHECs), the primary educational outreach effort of UAMS. The AHECs provide patient care, serve as training sites for different health professions, and encourage rural practice choices. Area health education centers are located in El Dorado, Fayetteville, Ft. Smith, Helena, Jonesboro, Pine Bluff, Texarkana, and Batesville/Mountain Home.[144] Arkansas is also making use of technology such as telemedicine to enhance medical capacity in outlying areas, through programs such as the Center for Distance Health and ANGELS (Antenatal and Neonatal Guidelines, Education and Learning System).[145]

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Challenges

While Arkansas does slightly better than the national average in terms of the percentage of medically disenfranchised individuals, most of its counties are considered at least partially medically underserved under US Department of Health guidelines. The Arkansas Department of Health classifies only 2 counties (Boone and Grant) as having adequate access to medical services under federal guidelines. The same study that found Arkansas better than the national average for medical disenfranchisement also reported that the state fares much worse than average in the percentage of uninsured residents who have no usual source of care. This includes many Arkansans living with HIV/AIDS (eg, 47% of Ryan White Part B clients have no insurance).[146] While the percentage of medically disenfranchised reflects the impact of physician shortages on primary care, reports of lacking a usual source of care tend to consider multiple and even compounding access barriers, such as those often faced by people living with HIV/AIDS (stigma, poverty, lack of transportation).[147] Arkansas was fifth worst in the nation in 2005 in uninsured lacking a usual source of care, ranking ahead of only Florida, Arizona, New Mexico, and Texas. The following chart compares Arkansas to nearby states in this category:

Percent of Uninsured Adults Without a Usual Source of Care, 2005[148]

Tennessee	33.7%
Mississippi	38%
Alabama	41.1%
Missouri	41.8%
Louisiana	49.5%
Oklahoma	50%
Arkansas	**50.2%**
Texas	60.2%

For people living with HIV/AIDS, finding good healthcare can be even more difficult, both in Arkansas and across the country. A recent survey by the American Academy of HIV Medicine indicated that nearly one-third of surveyed HIV healthcare providers (including physicians, physician assistants, and nurse practitioners) intend to stop practicing over the next 10 years.[149] Arkansas has relatively few doctors qualified and willing to provide HIV care. Reasons for the shortage of HIV physicians include the specialized training needed, the relatively low reimbursement rates (especially in the Medicaid program), and the stigma associated with HIV-affected individuals. Arkansas AIDS service organizations and consumers also report particular shortages of mental health and dental providers.

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The shortage of HIV specialists means that people living with HIV, particularly in rural areas, must either wait a long time or travel a long distance (or sometimes both) to receive HIV specialty care. Further compounding this problem is the reluctance of rural HIV-positive Arkansans to seek care locally, because of stigma and fear of having their status disclosed. One rural provider reports that clients travel 240 miles round-trip to get care. Public transportation is virtually nonexistent outside of the more urban areas, and the high cost of private transportation is a barrier both for low-income people living with HIV/AIDS and for the resource-strapped organizations that try to help them. Transportation is not considered a "core service" under Ryan White Part B, meaning that any transportation expenses must come out of the 25% of funds available for support services (rather than the 75% available for core services). Even if organizations can provide gas cards to offset the cost of transportation, many rural residents do not have vehicles and are hesitant to ask to borrow one from family or friends because it would mean disclosing information about their health.

Long waits for appointments and long travel times caused by the shortage of providers compromises standards of care for people living with HIV/AIDS, and can negatively affect their health. Research has found that lack of a primary care provider (including a nurse practitioner or physician assistant) leads to worse outcomes for HIV-positive patients. In addition to poor health outcomes for individuals, the lack of physicians can also lead to damaging public health consequences. Individuals whose access to care is erratic may be less likely to adhere to treatment regimens, leading to the development of drug-resistant strains of HIV. Individuals who do not have consistent healthcare may be more likely to engage in behaviors that can spread HIV.[151] They may also have higher viral loads, making them more likely to transmit HIV if they do engage in risky behaviors.

Opportunities

Greater integration of HIV care into existing systems of care

While the availability of federal Ryan White funding has provided lifesaving access to care and services across the nation, the development of Ryan White service delivery systems has meant that HIV is sometimes not as integrated into other care systems as it should be. Particularly with Ryan White funding not keeping pace with the need for care, and because Arkansas receives the least federal Ryan White funding of any southern state, it is important to maximize the use of existing healthcare resources in Arkansas to provide care to Arkansans living with HIV/AIDS.

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The Arkansas Department of Health (ADH) has recognized the need for greater coordination and communication between Ryan White Part B providers and private physicians. HIV care and services should also be incorporated more fully into the practices of community health centers and the area health education centers, and HIV awareness, prevention, and services information can be included in Hometown Health Improvement initiatives. One provider suggested using Arkansas's network of home health workers to collect blood samples for laboratory work from rural Arkansans living with HIV. Another advantage to integrating HIV care into multiservice healthcare practices is that it can help avoid the stigma associated with going to an HIV-specific clinic.

Create "one-stop shops"

Both service providers and consumers lamented the lack of "one-stop shops" in Arkansas—places where people living with HIV/AIDS could get all the medical and social services they needed in one place, without needing to travel around to multiple sites. Integrating HIV care into facilities that provide other types of care, as outlined above, is one approach. Adding additional services to HIV medical provider sites is another. The University of Arkansas for Medical Sciences (UAMS) clinic, which is already one of Arkansas's largest providers of medical services to people living with HIV, could be one place to pilot a one-stop shop model. Services could include medical and nonmedical case management, nutrition support, outreach workers for Medicaid and the AIDS Drug Assistance Program, and ideally also mental health and substance abuse services. While UAMS currently does not do HIV case management and has not been a Ryan White contractor in the past,[153] Arkansas Department of Health could investigate building a partnership with this important medical provider.

Another one-stop shop model, not necessarily specific to HIV, is the Jackson Medical Mall (JMM). Created from an abandoned mall in Jackson, Mississippi, JMM is a mix of healthcare providers, social/human service agencies, state and city government offices, university classroom and conference space, retail shops, and restaurants. The JMM Foundation serves as the management arm of the mall, and focuses on holistic healthcare for the underserved and on community economic development in the area surrounding the mall.[154]

Take the show on the road

A mobile health van is another possible mechanism for bringing care and services to Arkansans for whom access to care is difficult. Because of stigma, it would be important that any such mobile program encompass more than just HIV-related care. While a clinic on wheels may not lend itself to more complex treatment, a mobile van could provide at a minimum health screenings and basic examinations, and could deliver medications.

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Use federal programs to help recruit providers and explore other sources of providers

The federal National Health Service Corps (NHSC), part of Health Resources Services Administration (HRSA), helps communities recruit and retain healthcare providers, and provides loan forgiveness for clinicians who work in health professional shortage areas. But the NHSC loan forgiveness program applies only to primary care providers, not to specialists.[155] Many of the sites that qualify for NHSC participation, such as federally qualified health centers or rural health centers, do not have expertise in HIV treatment. Working with HRSA to create a federal requirement that NHSC sites have HIV treatment expertise, or the ability to link patients to a site that does, would improve access to care for Arkansans living with HIV disease in medically underserved areas. Arkansas could also explore what other largely rural states do to attract healthcare providers, and could investigate recruiting healthcare providers from outside the United States.

Consider designating advanced practice nurses as primary care providers

A study in the *Annals of Internal Medicine* found that the quality of care provided by nurse practitioners and physician assistants was similar to or better than care provided by doctors in HIV clinics.[156] Under Arkansas law, advanced practice nurses (APNs) are not considered primary care providers and consequently are reimbursed at rates lower than a physician would be for providing the same service. Currently, Arkansas BlueCross BlueShield reimburses nurse practitioners who bill under their own numbers at 75% of the full fee schedule.[157]

A bill in the last legislative session (HB 1134) would have eliminated the mandate for collaborative practice agreements between APNs and physicians, and allowed APNs to be designated as primary care providers. With a primary care provider designation, APNs would have been entitled to equal reimbursement from insurance companies for performing the same services as physicians.[158] The bill died in committee.

The lower reimbursement rates for APNs mean that clinics that use APNs to provide services can suffer damaging economic consequences, since clinics receive lower payments when APNs provide the same services that doctors do. But clinics may be using APNs because physicians are not available. The current reimbursement structure has the potential to create perverse economic incentives for clinics to turn patients away at the door, rather than incur further financial losses by treating them. Increasing reimbursement rates for APNs across the board would help correct this. At a minimum, facilities that can certify that they are unable to get a physician to provide services should get increased reimbursement rates from insurers for APN services.

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Use telemedicine to improve provider capacity

For medical practitioners in rural Arkansas who may not be familiar or comfortable with diagnosing and treating HIV/AIDS, telemedicine and consult lines could be valuable resources. The University of Arkansas Medical Sciences is already using technology to share expertise between tertiary care centers and smaller facilities. Enabling Arkansas's HIV specialists to share their knowledge and experience could improve the quality of the care received by HIV-positive Arkansans in more outlying areas.

Use the continuing medical education requirement to improve provider capacity

Arkansas physicians are required to have 20 hours of continuing medical education (CME) credits annually.[159] The Arkansas State Medical Board should consider requiring physicians to have at least 1 hour of HIV-related CME credit every 2 years. The CME should incorporate training on how to identify symptoms of HIV (and how HIV manifests differently in men and women), current treatment options and standards of care, common comorbidities such as mental health issues and substance abuse, and related psychosocial issues, like stigma.

AIDS DRUG ASSISTANCE PROGRAM

Challenges

The most immediate challenge facing people enrolled in Arkansas's AIDS Drug Assistance Program (ADAP) is a potential funding shortfall that has led the Arkansas Department of Health (ADH) to cut some drugs from the formulary and reduce income eligibility levels for the program from 500% of FPL earlier in 2009, to 200% of FPL in May 2009, to 150% of FPL as of November 16, 2009.[160] Arkansas's ADAP also instituted a waitlist, after not having had one since 2006. Close and assertive management of ADAP by ADH enabled the income eligibility level to return to 200% FPL as of early 2010 and allowed individuals on the waitlist to be enrolled in the program. As of April 1, 2010, no one was on the ADAP waitlist. The ADAP cuts were projected to remove 49 people from the program, beginning in January 2010. As of February 2010, Medicaid recipients are no longer eligible for ADAP.

The combination of reduced federal funding and significantly increased enrollment (up 54% from 2008 to 2009) led ADH to announce the ADAP eligibility cuts.[161] AIDS Drug Assistance Program enrollees scheduled to be cut from the program have been encouraged to apply to pharmaceutical companies' patient assistance programs, but providers report that not all clients will be eligible for these programs. It is highly likely that some clients will lose access to their medications, a situation that has serious implications for both individual and public health. HIV treatment regimens are complex, and require consistent adherence. Without continuous access to medications, patients can become nonresponsive to their treatment and develop drug-resistant strains of HIV. While ADH will apply for competitive federal supplemental ADAP funding in 2010, the underlying issue of the lack of any state contribution for ADAP remains.

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Other challenges with ADAP stem from a lack of oversight of the program on the part of ADH in past years. The AIDS Drug Assistance Program had no coordinator for a number of years, and functions that could have been more efficiently administered centrally were instead delegated to community-based case managers, through whom clients needed to get prescription refills. This created a more cumbersome and expensive process. There has also been a "use it or lose it" perception about ADAP on the part of some clients—that if all prescriptions were not refilled entirely (even if not needed), people would lose their ADAP eligibility. The current ADH staff is working to address these issues.

Opportunities

Support emergency federal funding for ADAP

The economic downturn has significantly increased demand on ADAPs across the country, resulting in funding shortfalls and waitlists. According to the National Alliance of State and Territorial AIDS Directors (NASTAD), as of January 7, 2010, there were 540 individuals on ADAP waitlists nationwide—a 1,155% increase from January 2009. NASTAD and other national experts estimate that an additional $126 million in federal funding for FY2010 is needed to meet current program needs. This funding should be distributed first to states eligible for ADAP supplemental grants (including Arkansas). Advocates should ask the Arkansas Congressional delegation to support emergency ADAP funding.

Explore using the Comprehensive Health Insurance Pool and amend state law as needed

Arkansas's Comprehensive Health Insurance Pool (CHIP) was created in 1995 to provide insurance for Arkansas residents with high-risk conditions who were otherwise unable to obtain health insurance. The program has calendar-year deductibles ranging from $1,000 to $10,000, and has different monthly premiums depending on the deductible chosen, gender, age, and tobacco use. Prescription drugs are covered at a rate of 80%.[162]

Other states, such as Oregon, make use of high-risk insurance pools to obtain health (and prescription) coverage for people living with HIV, using AIDS Drug Assistance Program (ADAP) funds to purchase insurance. This leverages limited ADAP funds and allows Oregon to ensure that many more people have prescription coverage than if ADAP purchased medications directly. Unfortunately, this option is not currently available in Arkansas, as the General Assembly passed a law in 2009 prohibiting the use of employer or government funds to pay CHIP premiums.[163] According to the Arkansas Insurance Department, this law was prompted by concerns about insurance agents and employers trying to use CHIP as a vehicle for providing group health insurance.[164]

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The Arkansas Department of Health may want to look at other states' use of high-risk insurance pools, and conduct an economic analysis to see whether using ADAP funds for CHIP would enable more people to obtain prescription coverage. If it turns out to be an efficient use of ADAP monies, Arkansas lawmakers should consider amending state law to permit this option.

OTHER HEALTHCARE ACCESS CHALLENGES

Mental health and substance abuse treatment services

In Arkansas, mental health and substance abuse treatment services fall under the direction of the Department of Human Services (DHS), rather than under the Arkansas Department of Health (ADH). There is a lack of coordination and communication among mental health, substance abuse, and HIV/AIDS programs, despite the fact that these programs are often serving the same clients. People living with HIV/AIDS very commonly are multiply diagnosed with mental health and substance use issues. HIV services providers and consumers observe that the quantity and quality of mental health and substance abuse services is often not adequate, and that finding a way to pay for substance abuse treatment can be difficult. The Ryan White funding allocated for mental health covers only an assessment, not ongoing treatment. While the merging of DHS and ADH in the past is widely viewed as a failure, Arkansas should at least consider moving mental health and substance abuse (both significant health issues) under the jurisdiction of ADH. At a minimum, there must be more communication, coordination, and collaboration among these program areas to better meet the needs of clients.

Housing

The lack of safe, affordable, stable housing has serious negative effects on the ability of a person living with HIV/AIDS to access and remain in care. One Delta-area provider reports that clients cannot even get on a waiting list for subsidized housing, because the lists are already years long. Another provider notes that most of her clients "keep moving" because they cannot afford their rents, which interrupts their healthcare and makes it significantly more difficult to provide case management services. There are waitlists in all districts for housing, and transitional programs can become *de facto* permanent programs when clients have nowhere else to go and no funds to move.

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Transportation

Transportation is a challenge in both rural and urban areas. The lack of public transportation in rural areas adds an extra obstacle for consumers trying to get to medical and social services appointments. Some providers report that while clients can pay to get on the "Medicaid van," the cost is prohibitively expensive for both the clients themselves and for small organizations. Even if people have their own vehicles, the high cost of fuel and the long travel distances involved in rural areas can pose serious barriers. In urban areas, limitations on the number of bus passes allowed by AIDS service organizations means that clients often do not have enough passes to get to all their appointments in any given month. Transportation challenges are magnified for people who are nonambulatory, especially as many areas of Arkansas (including parts of urban areas) lack adequate sidewalks.

Corrections-related issues

Arkansas has 2 state agencies that deal with corrections: the Arkansas Department of Corrections (ADC), which is responsible for state prisons, and the Department of Community Corrections, which oversees local/county jails. Inmates in Arkansas prisons are tested for HIV both upon incarceration and before release. Both Jefferson Comprehensive Care System, Inc. and White River Rural Health operate programs to provide care and services to inmates in Arkansas prisons. The Arkansas Department of Health (ADH) is also working in collaboration with ADC to develop a program, "Corrections to Care," that will work to link inmates to HIV care and services upon release. HIV service providers and consumers note that the quality of care for inmates is uneven, and that there is currently not adequate discharge planning and pre-/post-release coordination with community resources. Providers and consumers report that Arkansas jails commonly release HIV-positive inmates so that they do not have to provide them with treatment. There needs to be more education about HIV for corrections officials (both medical and others), which hopefully will happen through collaboration between ADH and ADC in the Corrections to Care program.

Dental care access

Consumers and providers alike note that there are many areas of the state with not enough dentists willing to treat people living with HIV/AIDS, and not enough resources available to pay for dental services. As of November 2009, the Arkansas Department of Health has prioritized dental treatment plans based on an acuity scale, with Priority 1 representing dental conditions that hinder people from taking in adequate nutrition. Priority 1 clients will receive services as funding allows.[35]

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Culturally and linguistically competent services

In order to reach cultural and linguistic minority communities effectively with prevention education and to engage them in care, providers need culturally and linguistically competent staff. Many providers in Arkansas lack this capacity. One notable exception is the Community Clinic in Springdale, in northwest Arkansas, which has developed effective outreach programs to the local Marshallese and Hispanic communities. The clinic employs staff members who come from these communities, and tailors outreach programs to the cultural needs and sensibilities of the communities. By "meeting patients where they are," the Community Clinic has been able to engage these populations in prevention and care. Another area where cultural competence training is needed is for providers working with lesbian, gay, bisexual, and transgendered communities.

Lack of comprehensive, science-based health education

Arkansas does not mandate either sex or HIV education in schools—if sex or HIV education is provided, it must stress abstinence and is not required to discuss contraception.[166] From 2005 to 2006, the teen birth rate in Arkansas increased 5%, and Arkansas ranked fourth among US states in 2006 for number of teen births.[167] Arkansas also has relatively high rates of sexually transmitted infections.[168] It is obvious from Arkansas's teen birth rate that many adolescents are sexually active. The lack of comprehensive, science-based sex and health education (including information about HIV/AIDS) misses an important opportunity for HIV, STD, and pregnancy prevention, and means that Arkansas youth are not provided with potentially lifesaving information.

appendix A:

Arkansas HIV/AIDS Case Prevalence and Rates by County, 2007

POPULATION-ADJUSTED CHANGE IN CASE RATES OF PEOPLE LIVING WITH HIV/AIDS BY COUNTIES:

Rates as of 12/31/07 compared to 12/31/06, listed in descending order by case rate

Source: Arkansas Department of Health, Arkansas Statewide Coordinated Statement of Need & Comprehensive Plan 2009-2010.

Prevalence Rate of People Living With HIV/AIDS by Arkansas Counties as of 12/31/07			% Change In Case Rate/100,000 From 12/31/06
COUNTY	No. of Cases	Rate/100,000	
PULASKI	1694	461.2	↑5.7%
CRITTENDEN	235	451.2	↑5.4%
UNION	164	371.3	↑6.5%
ST FRANCIS	89	323.2	↓1.1%
PHILLIPS	69	295.7	↑4.5%
MILLER	123	285.7	↑3.4%
MONROE	23	252.9	↑4.5%
JEFFERSON	186	230.6	↑8.8%
OUACHITA	57	213.4	↑9.6%
WASHINGTON	383	205.3	↑6.1%
GARLAND	195	204.9	↑4.8%
SEBASTIAN	243	202.0	↑3%
CHICOT	25	193.6	↑4.2%
MISSISSIPPI	90	189.4	↑2.3%
CARROLL	49	179.2	↑11.4%
LEE	19	167.0	No change
DESHA	22	155.1	↑22.2%
HEMPSTEAD	36	154.2	↑5.9%
CRAIGHEAD	127	143.9	↑7.6%
COLUMBIA	32	130.9	↑6.7%
NEWTON	11	130.8	↑10%
LITTLE RIVER	16	122.4	No change

appendix A:

Arkansas HIV/AIDS Case Prevalence and Rates by County, 2007

Prevalence Rate of People Living With HIV/AIDS by Arkansas Counties as of 12/31/07			% Change In Case Rate/100,000 From 12/31/06
COUNTY	**No. of Cases**	**Rate/100,000**	
ARKANSAS	24	120.7	↓7.7%
CLARK	27	117.8	No change
CROSS	22	115.4	↑4.8%
ASHLEY	24	105.1	↑9.1%
LAFAYETTE	8	101.3	No change
BRADLEY	12	99.1	No change
GREENE	39	97.3	↑21.9%
CONWAY	20	96.6	No change
NEVADA	9	95.0	↑12.5%
SEVIER	15	92.0	↑15.4%
INDEPENDENCE	32	91.7	↑3.2%
CALHOUN	5	90.0	No change
CRAWFORD	51	86.8	↑4.1%
POPE	50	86.7	↑4.2%
MONTGOMERY	8	86.3	↑14.3%
BAXTER	33	79.9	↑ 6.5%
HOT SPRING	25	78.8	↓7.4%
WHITE	57	78.6	↑5.6%
HOWARD	11	76.3	No change
STONE	9	75.1	↑12.5%
BENTON	145	74.0	↑6.6%
POINSETT	18	71.8	↑28.6%
FAULKNER	72	71.5	↑9.1%
FRANKLIN	13	71.1	↓7.1%
DREW	13	70.7	No change
YELL	15	68.7	↑7.1%

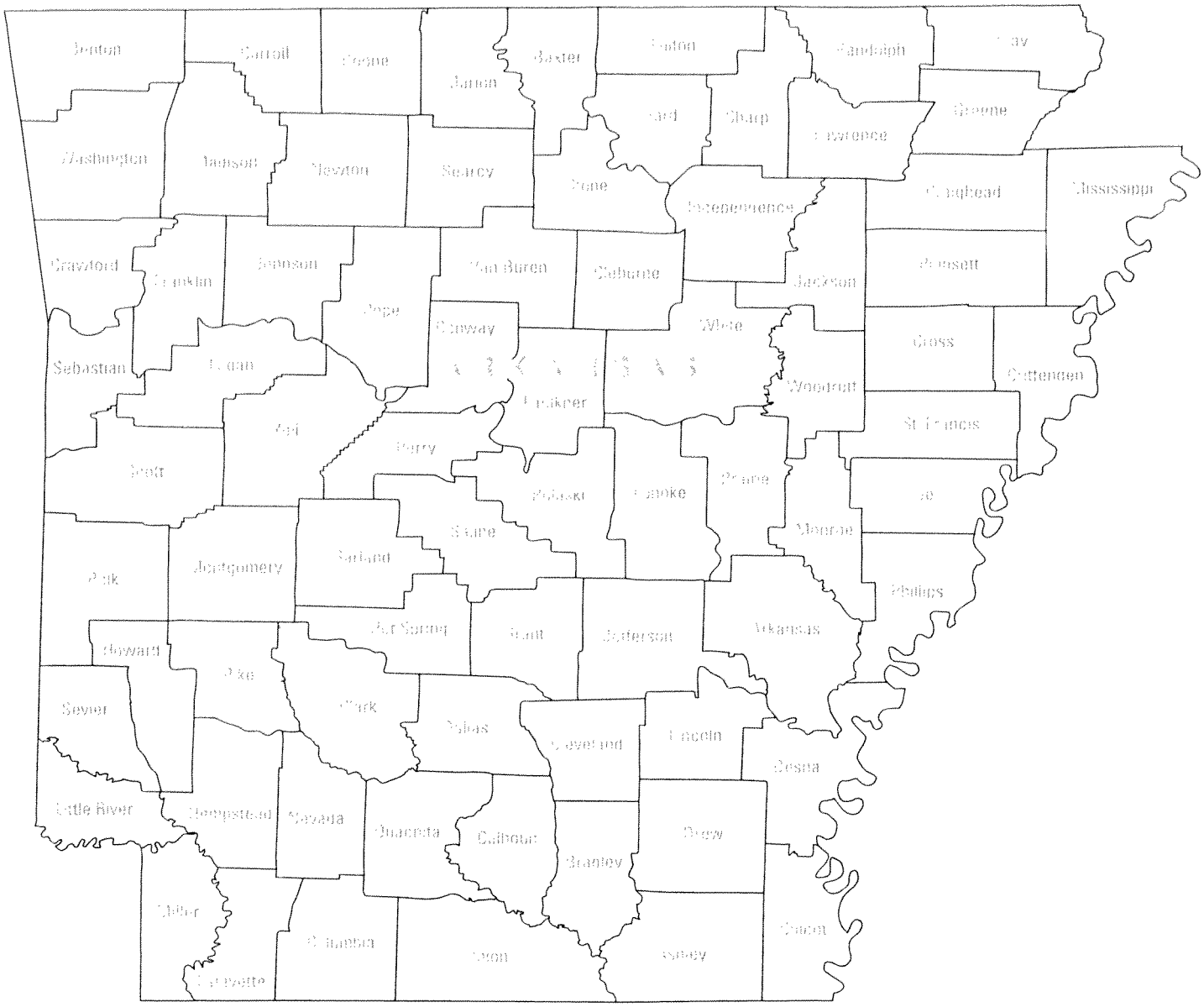
appendix A:

Arkansas HIV/AIDS Case Prevalence and Rates by County, 2007

Prevalence Rate of People Living With HIV/AIDS by Arkansas Counties as of 12/31/07			% Change In Case Rate/100,000 From 12/31/06
COUNTY	**No. of Cases**	**Rate/100,000**	
WOODRUFF	5	63.3	No change
JACKSON	11	63.1	↑10%
SEARCY	5	61.9	No change
IZARD	8	59.9	No change
DALLAS	5	59.9	No change
POLK	12	58.9	↑9.1%
LINCOLN	8	56.6	No change
PRAIRIE	5	56.0	No change
PIKE	6	55.3	↑20%
BOONE	20	54.9	↑5.3%
SALINE	50	53.2	↑4.2%
MARION	9	53.2	No change
MADISON	8	52.1	No change
SHARP	9	50.1	↑12.5%
LOGAN	11	48.0	No change
LONOKE	30	47.7	↑11.1%
SCOTT	5	43.8	No change
CLAY	7	42.4	↑16.7%
GRANT	7	40.0	↑16.7%
CLEBURNE	10	39.2	No change
RANDOLPH	7	37.9	No change
VAN BUREN	6	35.9	↑20%
FULTON	3	25.5	No change
JOHNSON	6	24.5	No change
CLEVELAND	2	22.6	No change
PERRY	2	19.2	No change
LAWRENCE	3	17.8	No change

appendix B:

Map of Arkansas Counties



appendix C:

2009 Federal Poverty Guidelines

THE 2009 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family	Poverty guideline (100% FPL)
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add $3,740 for each additional person.

Source: United States Department of Health and Human Services, http://aspe.hhs.gov/POVERTY/09poverty.shtml.

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